Eckerd Rapid Safety Feedback Field Staff Guide: New Hampshire

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What is Eckerd Rapid Safety Feedback?

There is no magical formula to prevent all child fatalities or other tragedies; however by using data to help determine which children are at the highest risk and providing real-time practice support on those cases, we can maximize available resources to achieve safe outcomes. The ERSF process is an innovative data-informed approach to quality improvement. Traditionally most child welfare quality assurance review processes have focused on what has already occurred, for example with completion of a retrospective file review after a critical incident or fatality. The ERSF model provides a proactive approach to QA by completing case reviews in real time, and providing immediate feedback, as needed, so intervention can occur before a tragedy occurs. The review focuses on the most critical safety-related issues, instead of traditional reviews that include a large volume of questions about a wide range of topics, which are equally weighed. Cases are not randomly chosen; in fact, ERSF reviews target our system's highest risk population.

ERSF was developed by Eckerd Kids, a Florida Community-Based Care Lead Agency that manages child welfare services in Hillsborough, Pinellas, and Pasco counties. It was developed in 2012 in response to an unprecedented nine child homicides in less than three years on cases open to in-home protective services under the supervision of the previous lead agency. ERSF has been identified as a best practice by the Los Angeles County Blue Ribbon Panel Commission on Child Protection[1], and was featured in the final report of the US Federal Commission to Eliminate Child Abuse and Neglect Fatalities[2] (CECANF). The model has been replicated in five states and is currently under development in four more. Casey Family Programs is collaborating with Eckerd to conduct an independent evaluation of this approach as it is being deployed in the early adopting jurisdictions.

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[1] John Kelly, "Los Angeles Eyes Florida's Child Fatality Prevention System," The Chronicle of Social Change 17 Sept. 2014. https://chronicleofsocialchange.org/featured/los-angeles-eyes-floridas-child-fatality-prevention-system/8132
John Kelly, "The Potential of Rapid Safety Feedback." The Chronicle of Social Change 18 Sept. 2014. https://chronicleofsocialchange.org/youth-services-insider/the-potential-of-rapid-safety-feedback/8139

[2] "Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities." *Commission to Eliminate Child Abuse and Neglect Fatalities Final Report*, 17 March 2016, http://www.cwla.org/wp-content/uploads/2016/03/CECANF_Final-Report_Embargo-until-3.17.16-1.pdf.

"High-Risk" Designation and Case Selection

Cases identified as "high risk" according to the ERSF model may not appear on the surface to be like cases traditionally considered to be high risk. The differences between risk determinations in traditional case practice and those used as part of the ERSF model are detailed in the chart below:

	Case Assessment Practice	Eckerd Rapid Safety Feedback
Desired Outcome	To prevent recurrence of child abuse or neglect	To prevent occurrence of the negative outcome described in the jurisdiction's ERSF problem statement*
How Risk Level Is Determined	A caseworker completes a risk assessment tool or process based on current case conditions and some historical information to determine the likelihood that some type of child maltreatment will occur at some time in the future.	ERSF uses historical data from an agency's case management system to determine which set of child and family characteristics have the greatest likelihood of resulting in the negative outcome described in the jurisdiction's ERSF problem statement.
What "High Risk" Means	High likelihood that some type of child maltreatment will occur at some time in the future	Highest risk of resulting in the negative outcome described in the jurisdiction's ERSF problem statement

**A problem statement is a description of the negative child safety outcome each jurisdiction intends to prevent. Some examples of ERSF problem statements are:*

- *Prevent fatality or life threatening episode of a child within 12 months of a prior accepted report.*
- *Prevent substantiated high severity maltreatment within 12 months of Department involvement.*

New Hampshire's Problem Statement

NH would like to prevent a fatality or serious injury to children known to the Department from a prior accepted report, regardless of finding, within 12 months of that previous accepted report.

RSF in New Hampshire

The NH Division for Children Youth and Families is implementing RSF as a quality assurance measure to better protect children in NH from fatality or serious injury. Although this has always been a primary goal of the Division, in 2015 there was recognition by Division administration, Department of Health and Human Services Administration, and the Governor of NH that changes to the Child Welfare System in NH were necessary. In 2015, the Governor requested an independent review of DCYF be conducted and the Center for the Support of Families was identified as the agency to conduct the review, which began in April of 2016. On December 19, 2016 the final report was completed by the Center for the Support of Families and presented publicly in NH. In this report, named the Quality Assurance Review of the Division of Children, Youth and Families, twenty separate recommendations were made to positively transform the Division and the entire NH Child Welfare System.

Recommendation 19 focused on improvements to child protection practice, stating that practice must "Re-conceptualize the process of identifying safety threats and risks of harm associated with incoming reports of maltreatment.[3]" The Center for the Support of Families further stated:

> "Our recommendation is that DCYF consider utilizing a predictive analytics approach, similar to what several other States have implemented. In a predictive analytics environment, the State's own data and experiences with children and families are used to identify children whose circumstances place them at high risk of maltreatment. Coupled with a modified internal CQI process that provides an initial and periodic review of children identified to be at risk and provides guidance to social workers assigned to the children, would provide added layers of protection and judgment to what is needed to respond appropriately. It would also take some of the burden off individual social workers and their supervisors to make decisions alone, and/or to assist them in building the case needed to ensure that the assessments are appropriately acted upon." – page 102

Based on this Quality Assurance Review, Division staff, in conjunction with Administrators from the NH Department of Health and Human Services and internal and external stakeholders, have come together to transform the entire child welfare system in New Hampshire. In response to Recommendation 19, the Division explored analytic tools to assist with the assessment and management of safety issues and risk to children and youth. It should be noted that Casey Family Programs has provided support to the Division in this effort.

Rapid Safety Feedback, through Eckerd Connects, was identified as a promising practice in this area and, therefore, has been adopted as the framework for an analytic model used by the

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[3] **The Center for the Support of Families. (2016, December 19). *Quality Assurance Review of the Division of Children, Youth and Families* (Rep. No. 1). Retrieved May 30, 2018, from New Hampshire Department of Health and Human Services website: https://www.dhhs.nh.gov/dcyf/documents/csf-qa-review-report.pdf**

Division to help manage safety for children and youth. The Division identified a problem statement that addresses the risk of severe child maltreatment and/or increased risk of child fatalities. Specifically, "NH would like to prevent a fatality or serious injury to children known to the Department from a prior accepted report, regardless of finding, within 12 months of that previous accepted report." The Division has worked collaboratively with Eckerd Connects to develop an implementation plan for Rapid Safety Feedback which has included developing a specific tool to evaluate safety practices in assessment, hiring staff to manage the program, training these RSF staff, educating DCYF Administrators and District Office Field Staff about RSF, and utilizing the tool on identified assessments. Additionally, the DCYF data team developed data parameters, reviewed the data, made modifications, and analyzed data trends to both implement RSF and evaluate the data once Mindshare began identifying assessments. On May 1, 2018 the practice of RSF was rolled out in the first 3 District Offices with the final roll out scheduled to be completed by January 2019. DCYF recognizes the value of this quality assurance process for highest risk assessments in order to mitigate risk and improve outcomes for children involved with the Division.

Continuous Quality Improvement

The Division will ensure that continuous quality improvement occurs consistently throughout the RSF process, using a number of processes to ensure good communication, fidelity, and practice improvement. RSF staff will continue to facilitate bi-weekly meetings of the RSF committee to discuss emerging trends, practice protocols, and concerns and strengths from the field. Eckerd staff will continue to work with RSF staff to ensure fidelity to the RSF model by conducting quarterly fidelity reviews of the work that RSF is doing in New Hampshire. RSF staff and other BOLQI staff will continue to examine casework trends, areas of training need, and good practices and communicate these trends to District Offices. RSF may also participate in assessment reviews with the goal of working cooperatively with BOLQI staff to design office Practice Improvement Initiatives that help to improve practice while also identifying areas where additional training is needed. Finally, RSF will present information about the program to the Leadership team on an ongoing basis so that the field is continuously provided with up-to-date information about RSF and has an opportunity to engage in ongoing practice discussions.

Process Overview

1. **Case Identification**: Mindshare, Eckerd's technology partner, uses historical data as described above to determine the probability that any child victim in an open investigation will experience the negative problem statement outcome, and provides the RSF team a daily listing of those children with the highest probability. The assigned reviewer sends an email notifying the current caseworker and supervisor that their assessment has been identified, as well as the date the assessment will be reviewed and will schedule a teaming via Outlook invitation.

2. **Case Review**: The Rapid Safety Feedback Coach completes a review of the current investigation, using the brief safety-focused review tool. As part of the review process, the reviewer will read the current investigation, prior investigations for all household members, and information from recent ongoing services cases. While case history is reviewed, the RSF review tool is completed based only on the current investigation and on current circumstances as documented in the case record.

3. **Scheduling the Teaming**: Upon case identification, the RSF team will notify the Child Protective Service Worker (CPSW) and CPSW's direct supervisor of the date of time a teaming is scheduled for. Once the review is completed and if any safety concerns are identified, or if there is not enough information documented to determine whether safety concerns exist, the case will be staffed. Teamings must occur within one business day of the review's completion, due to the safety-focused nature of the review. If there are no questions or concerns about the case the teaming will be canceled.

4. **The Teaming**: During the teaming, the RSF team and field staff will jointly discuss the case and devise a plan for further assessment and/or actions, if needed. The plan will include mutually-agreed-upon timeframes for completion of the action tasks that balance the urgency of the need with consideration of field staff's workload.

5. **After the Teaming**: The RSF team will send an email to the caseworker and supervisor following the teaming, which includes the action plan and timeframes, as well as strengths identified in the casework and non-safety-related recommendations (if applicable).

6. **Action Task Completion/Barriers:** Once action tasks are completed and documented in the state system, the caseworker or supervisor should communicate that to the RSF team. The field staff should also communicate if any barriers arise – action plans can be adjusted or extended if needed. If a task completion date arrives without documentation of completion or communication of barriers, the RSF team will send an email reminder to the caseworker and supervisor. It is important to respond promptly to this reminder in order to avoid the need for an accountability staffing.

7. **Accountability**: If actions are not completed, and the caseworker or supervisor does not communicate barriers to the RSF team, an accountability staffing will be scheduled.

This staffing is held between leadership from the quality and operations departments and consists of a discussion as to why agreed-upon action tasks were not completed timely and the creation of an immediate plan to rectify the concerns.

8. **Ongoing Reviews:** The RSF reviewer will continue to follow the investigation as long as it remains open, and will complete a second review prior to closure. The second review focuses on activities which have occurred since the initial review and may result in a second teaming if additional questions arise or opportunities to enhance safety are identified. It is requested that RSF-identified cases not be closed prior to completion of this second review; however, if an impending closure is communicated to the RSF team, the reviewer can complete the second review sooner, so as not to delay the closure. Additional reviews will be completed every 30 days the assessment remains open and every 3 months of a B-case or voluntary case.

What to Expect from an RSF Teaming

The CPSW and CPSW's direct supervisor will participate in the Teaming with the RSF Coach and their supervisor. The purpose of the teaming is to ask questions and clarify information in order to identify any additional actions needed to assure the child's safety. The reviewer has already read the case and the family's prior history, so the caseworker does not need to be prepared to do a formal presentation of the case, but rather to answer questions and discuss potential safety concerns.

CPSWs are the experts on both the case and what resources are available in the local area, so the information that they provide is invaluable to the review process. The CPSW knows what services are available and what will work best for the family. Because of this, the RSF reviewers should not develop the action plan for the CPSW.

The reviewer's role is to provide an outside, objective viewpoint which can help the caseworker to see the family and case from a fresh perspective. Through guided discussion about case circumstances, the teaming team will identify together what additional steps are needed to sufficiently assess and address child safety; then with assistance from the RSF reviewers, the caseworker and supervisor will develop this plan. Sometimes the RSF team may make suggestions of action tasks or ways to enhance the actions that were identified, but the CPSW's and Supervisor's input and agreement should be obtained.

Teaming does NOT mean	Teaming DOES mean
Removal must occur The casework was poor A "gotcha" situation You'll be told what to do Your expertise won't be valued	Shared risk and responsibility Collaboration between field & QA staff Open communication & respect A "second set of eyes" looking at the case A jointly-developed action plan

Frequently Asked Questions

Q – I was notified that my case was identified for review. What can I do to prepare?

A – Ensure all information has been documented in the case file. Any supervisory guidance should be entered as a supervisory review note, with a clear plan for next steps and timeframes. This is to ensure the quality reviewer has all the information needed to complete the review. Remember, more information documented in advance of the review makes it less likely a teaming will be needed. Give yourself credit for all of your great work!

Q – ***How does RSF's use of historical information predict how likely a child is to experience the negative outcome in the problem statement?***

A – RSF's predictive model is created based on the characteristics of children in the historical data who experienced the negative outcome in the past. The model then indicates how likely a child on an open case is to experience the negative outcome in the future based on his/her similarities to the characteristics of children who have experienced it in the past.

Q – ***Why was a child on my caseload determined to be at high risk of experiencing the negative outcome in the problem statement when the current allegations are not that severe? I have a child in another case with much more serious concerns who was not determined to be high risk.***

A – While current allegations are often a factor in a child's risk identification, they may not be the strongest indicator of the problem statement outcome. An isolated serious child maltreatment incident for one child, while certainly concerning, may not match the historical profile for the problem statement outcome, whereas another child's characteristics do, despite a relatively minor incident.

Q – ***I know that research has shown that children under three are the most likely to experience an abuse or neglect fatality. Why are older children being predicted?***

A – The problem statement identified by the jurisdiction plays a major role in which children are identified as "high risk." For example, if sexual abuse were part of the problem statement outcome, you would expect to see a different, likely older, population of children being predicted than you would using a problem statement that focuses strictly on child fatality.

Q – ***Why did this child on my caseload suddenly show up as high risk in RSF two weeks after the beginning of the investigation rather than at its start?***

A – The process of identifying cases for review is designed to adapt to changes in case circumstances. So a child's RSF risk level can change from one day to the next if new data is entered which impacts the child's risk analysis. Some examples of this include: 1) if a new

investigation is linked to an existing assessment that has significant prior history attached; 2) if a new household member is added to the investigation; and 3) if a new report is received.

New Hampshire's RSF Review Questions

1. Is background information, including DCYF history, documented for all household members and others with access to the child/victim, and incorporated into case decision-making?
   Considerations: The reviewer must assess overall evidence supporting:
   - Whether a background assessment was made of any parents and caretakers residing in and out of the home, including prior abuse or neglect history, or DCYF Family Services, and criminal background (if accessible)
   - If there are other adults residing in or frequenting the home, such as a paramour or relative, whether their identity and level of interactions with the child/victim were determined, as well as sufficient exploration of their background

   Rating Criteria:

   ☐ Yes, if background information, including DCYF history, was documented for all household members and others with access to the child/victim, and incorporated into case decision-making

   ☐ No, if background information, including DCYF history, was not documented for all household members and others with access to the child/victim, and/or was not incorporated into case decision-making

2. Are contacts with the family conducted with sufficient timeliness to assess safety and dynamic risk factors and to monitor safety plans?
   Considerations: The reviewer must assess overall evidence supporting:

   - Whether all alleged victims were seen and interviewed
   - Whether all non-victim children involved in the assessment were seen and interviewed, such as household members or children who do not reside in the household but are routinely in the home or care of the alleged perpetrators
   - Whether contact was made with all parents and caregivers, including non-custodial parents who are perpetrators or have direct knowledge of the allegations (unless engaging the non-custodial parent would pose an imminent risk to the child and/or custodial parent)
   - Whether the family was observed with sufficient frequency, as warranted by case circumstances, to provide a clear picture of family dynamics specific to safety and risk of future danger

   Rating Criteria:

   ☐ Yes, if contacts with the family were conducted with sufficient timeliness to assess safety and dynamic risk factors and to monitor safety plans

☐ No, if contacts with the family were not conducted with sufficient timeliness to assess safety and dynamic risk factors and to monitor safety plans

3. Are interviews and observations of sufficient quality to assess safety, risk of future danger, and the presence or absence of child vulnerability factors and parental protective capacities?

   Considerations: The reviewer must assess overall evidence supporting:

   - Whether safety and risk factors were explored, as well as their impact to the child
   - Whether the child was interviewed apart from the parent
   - Whether parental protective factors were explored, including:
     - Providing for the child's basic needs
     - Demonstrating effective problem-solving
     - Exhibiting self-control and putting the child's safety ahead of his or her own needs and wants
     - Acting to protect the child from danger
   - Whether the presence of underlying family conditions (such as domestic violence, substance abuse, and mental health issues) was sufficiently assessed along with their effect on risk of future harm, particularly with regards to infants and young children
   - Whether child vulnerability factors were explored (e.g. age, diminished physical/emotional/cognitive capacity to protect self, or repeated victimization) and how they change the impact of safety concerns or danger
   - Whether the case record included a description of the caregiver/child relationship, including observations of how they interact with each other

   Rating Criteria:

   ☐ Yes, if interviews and observations were of sufficient quality to assess safety, risk of future danger, and the presence or absence of child vulnerability factors and parental protective capacities

   ☐ No, if interviews and observations were not of sufficient quality to assess safety, risk of future danger, and the presence or absence of child vulnerability factors and parental protective capacities

4. Are the child's living environment and conditions sufficiently assessed, including sleeping arrangements as appropriate for child's age, and are identified concerns addressed?
   Considerations: The reviewer must assess overall evidence supporting:

   - Whether the living situation was assessed for conditions which are threatening to the child's health or safety based on age or developmental status
   - Whether safe sleep was discussed with all parents/caretakers and sleeping environment was observed as needed for infants
   - Whether measures were taken to promptly correct any safety hazards in the home, and/or sleep environment (for younger children as needed)

Rating Criteria:

☐ Yes, if the child's living environment and conditions were sufficiently assessed, including sleeping arrangements as appropriate for child's age, and identified concerns were addressed

☐ No, if the child's living environment and conditions were not sufficiently assessed, including sleeping arrangements as appropriate for child's age, or identified concerns were not addressed

5. Is communication and collaboration with collateral contacts sufficient to gather information regarding danger, risk of future danger, and family conditions?
Considerations: The reviewer must assess overall evidence supporting:
   - Whether collateral contacts were made with individuals who are in a position to provide insight into family relationships, patterns of behavior, and family functioning/dynamics (e.g. relatives, neighbors, service providers, law enforcement, medical providers, reporter)
   - Whether collateral contacts were pertinent to the allegations or issues that arose in the assessment and sufficient to support or refute allegations of abuse and/or neglect
   - Whether sufficient information was shared with those responsible for decision-making, service provision, and/or monitoring of child safety both initially and ongoing as circumstances change
   - Whether staff sufficiently reconciled conflicts of information provided by collateral contacts

   Rating Criteria:

   ☐ Yes, if communication and collaboration with collateral contacts sufficient was to gather information regarding danger, risk of future danger, and family conditions

   ☐ No, if communication and collaboration with collateral contacts was insufficient to gather information regarding danger, risk of future danger, and family conditions

6. If needed, did the use of safety interventions control for danger and risk of future danger?
Considerations: The reviewer must assess overall evidence supporting:
   - Whether the safety and risk assessments informed decisions of whether the victim/child could safely remain in the home, and the need for interventions to eliminate the threat of immediate harm
   - If necessary to ensure child safety, whether a safety plan was created which:
     - Included a strategy to mitigate safety concerns and risk of future danger
     - Was sufficient to address the identified danger
     - Was monitored sufficiently

- Whether sufficient monitoring of the safety plan occurred as long as dangers remained, and the safety plan was modified as needed to ensure safety

Rating Criteria:

☐ Yes, if the use of safety interventions controlled for danger and risk of future danger

☐ No, if the use of safety interventions did not control for danger and/or risk of future Danger

☐ N/A, if no safety interventions were needed

7. If needed, are referrals, recommendations, and services appropriate to meet the family's needs identified and provided?
   Considerations: The reviewer must assess overall evidence supporting:
   - Whether the worker identified the need for services to address specific behaviors and/or conditions that put the family at risk, including those contributing to danger and/or risk of future danger, child vulnerability, and deficiencies in parental protective factors
   - Whether follow up occurred to ensure that families received and engaged in needed services
   - Whether the agency assisted the parents in overcoming barriers to service linkage

   Rating Criteria:

   ☐ Yes, if services appropriate to meet the family's needs were identified and provided

   ☐ No, if services appropriate to meet the family's needs were not identified and/or were not provided

   ☐ N/A, if no services were needed

8. Does the supervisory review identify gaps regarding all of the above, provide relevant and sufficient guidance, and ensure accountability to guidance?
   Considerations: The reviewer must assess overall evidence supporting:
   - Whether the case record contained evidence of supervisory oversight of casework related to all of the areas identified above
   - Whether the supervisory review included information about the assessment of child safety, risk of future danger, child vulnerability, and parental protective capacity
   - Whether the supervisor gave case-specific guidance to address gaps in information needed to adequately assess and respond to the family's needs
   - Whether the supervisor ensured the guidance was completed timely

   Rating Criteria:

   ☐ Yes, if the supervisory review identified gaps regarding all of the above, provided relevant and sufficient guidance, and ensured accountability to guidance

☐ No, if the supervisory review did not identify gaps regarding all of the above, provide relevant and sufficient guidance, and/or ensure accountability to guidance